WEEKLY EPIDEMIOLOGY BULLETIN

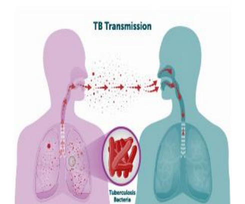
NATIONAL SURVEILLANCE UNIT, MINISTRY OF HEALTH & WELLNESS, JAMAICA

Weekly Spotlight

Tuberculosis (Part 3)

Multidrug-resistant TB (MDR-TB)

Drug resistance emerges when TB medicines are used inappropriately; through incorrect prescription by health care providers, poor quality drugs, or patients stopping treatment prematurely. MDR-TB is a form of TB caused by bacteria that do not respond to rifampicin and isoniazid, the two most effective first-line TB drugs. MDR-TB is treatable and curable by using other drugs, which tend to be more expensive and with more side effects. People exposed to MDR-TB may receive TB preventive treatment with levofloxacin. In some cases, extensively drug-resistant TB or XDR-TB can develop. TB caused by bacteria that do not respond to the most effective drugs in MDR-TB treatment regimens can leave patients with very limited treatment options. MDR-TB remains a public health crisis. Only about 2 in 5 people with multidrug-resistant TB accessed treatment in 2024. In accordance with WHO guidelines, detection of MDR-TB requires bacteriological confirmation of TB and testing for drug resistance using rapid molecular tests or culture methods. In 2022, new WHO guidelines prioritized a short 6-month all-oral regimen known as BPaLM/BPaL as a treatment of choice for eligible patients. Globally in 2024, approximately 34 000 people with MDR/RR-TB were reported to have started treatment on the 6-month shorter regimens (known as BPaLM and BDLLfxC), a substantial increase from 5653 in 2023 and 1744 in 2022. The shorter duration, lower pill burden and high efficacy of this novel regimen can help ease the burden on health systems and save precious resources to further expand the diagnostic and treatment coverage for all individuals in need. WHO recommends expanded access to all-oral regimens.



TB and HIV

People living with HIV are 12 times more likely to fall ill with TB disease than people without HIV. TB is the leading cause of death among people with HIV. HIV and TB form a lethal combination, each accelerating the other's progress. In 2024, about 150 000 people died of HIV-associated TB. The percentage of people who fell ill with TB and had a documented HIV test result was 82% in 2024. This was a slight increase from 81% in 2023. The WHO African Region has the highest burden of HIV-associated TB. Globally in 2024, only 61% of the estimated number of people living with HIV who developed TB received antiretroviral therapy (ART). WHO first recommended collaborative TB/HIV activities to reduce morbidity and mortality from HIV-associated TB in 2004. These activities include bidirectional screening, prevention and treatment of infection and disease. Scale-up of TB treatment and ART since 2005 is estimated to have averted 9.8 million deaths.

Impact

TB mostly affects adults in their most productive years. However, all age groups are at risk. Over 80% of cases and deaths are in low- and middle-income countries. TB occurs in every part of the world. Globally, about 50% of people treated for TB and their households face total costs (direct medical expenditures, non-medical expenditures and indirect costs such as income losses) that are catastrophic (>20% of total household income). This is far from the target of the WHO End TB Strategy of zero. Those with compromised immune systems, such as people living with HIV, undernutrition or diabetes, or people who use tobacco have a higher risk of falling ill. Globally in 2024, there were an estimated 0.97 million new TB cases that were attributable to undernutrition, 0.93 million to diabetes, 0.74 million to alcohol use disorders, 0.70 million to smoking and 0.57 million to HIV infection.

Taken from WHO website on 30/Mar/2026
https://www.who.int/news-room/fact-sheets/detail/tuberculosis
Picture taken from https://www.cdc.gov/tb/causes/index.html

EPI WEEK 11

Syndromic Surveillance
Accidents
Violence
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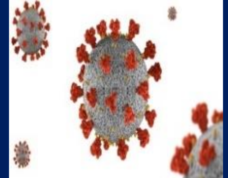

COVID-19 Surveillance
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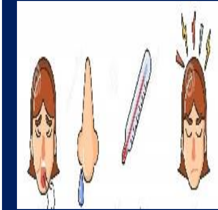

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Sentinel Surveillance in Jamaica

A syndromic surveillance system is good for early detection of and response to public health events.

Sentinel surveillance occurs when selected health facilities (sentinel sites) form a network that reports on certain health conditions on a regular basis, for example, weekly. Reporting is mandatory whether or not there are cases to report.

Jamaica's sentinel surveillance system concentrates on visits to sentinel sites for health events and syndromes of national importance which are reported weekly (see pages 2 -4). There are seventy-eight (78) reporting sentinel sites (hospitals and health centres) across Jamaica.

Table showcasing the Timeliness of Weekly Sentinel Surveillance Parish Reports for the Four Most Recent Epidemiological Weeks – 8 to 11 of 2026.

Parish health departments submit reports weekly by 3 p.m. on Tuesdays. Reports submitted after 3 p.m. are considered late.

KEY:
Yellow- late submission on Tuesday
Red – late submission after Tuesday
White- No reports received

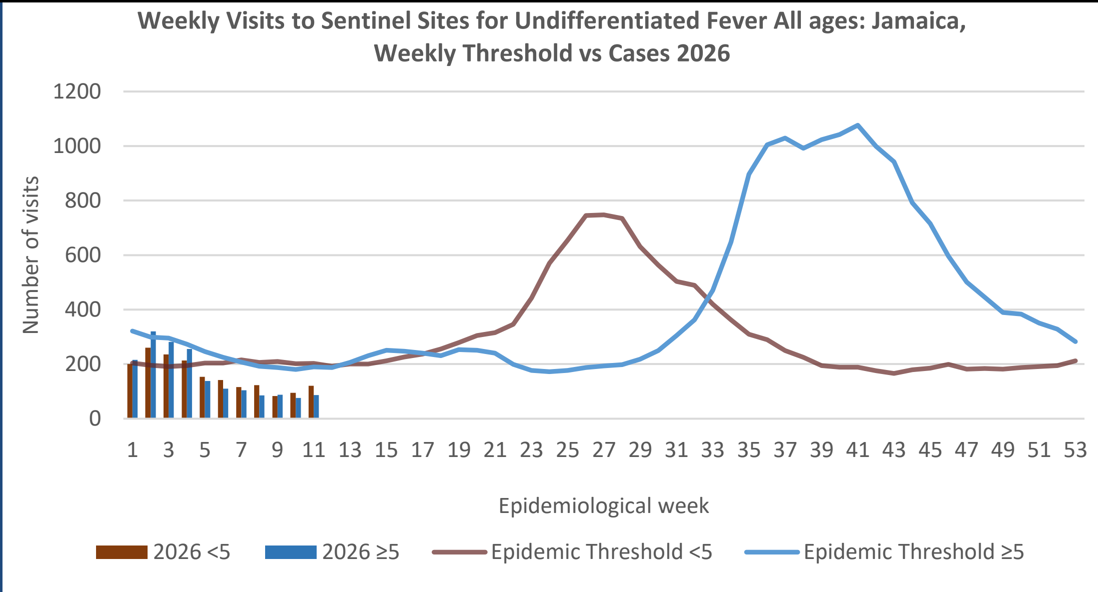
Epi week	Kingston and Saint Andrew	Saint Thomas	Saint Catherine	Portland	Saint Mary	Saint Ann	Trelawny	Saint James	Hanover	Westmoreland	Saint Elizabeth	Manchester	Clarendon
2026													
8	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time
9	On Time	On Time	On Time	On Time	On Time	On Time	On Time	Late (T)	On Time	On Time	On Time	On Time	On Time
10	On Time	On Time	On Time	On Time	On Time	Late (T)	On Time	On Time	On Time	On Time	On Time	On Time	On Time
11	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time	On Time

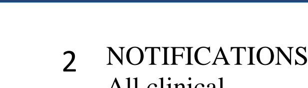
SYNDROMIC SURVEILLANCE

FEVER

UNDIFFERENTIATED FEVER

Temperature of >38⁰C /100.4⁰F (or recent history of fever) with or without an obvious diagnosis or focus of infection.





NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events

HOSPITAL ACTIVE SURVEILLANCE- 30 sites. Actively pursued

SENTINEL REPORT- 78 sites. Automatic reporting

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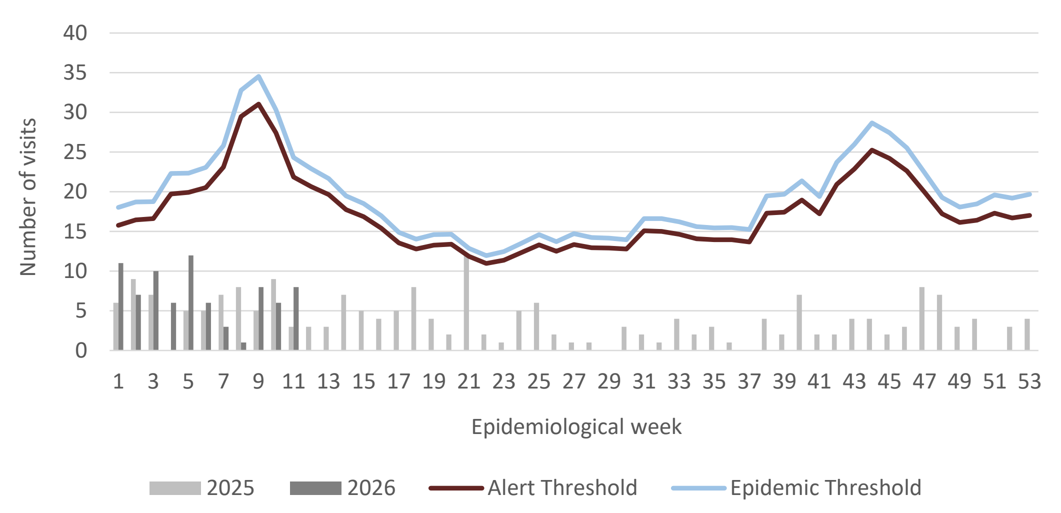
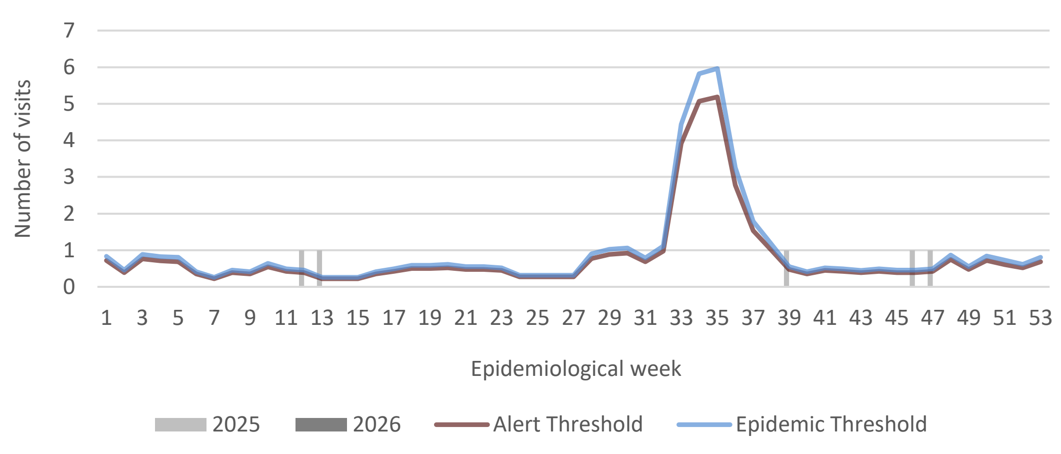
FEVER AND NEUROLOGICAL

Temperature of >38⁰C /100.4⁰F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).



FEVER AND HAEMORRHAGIC

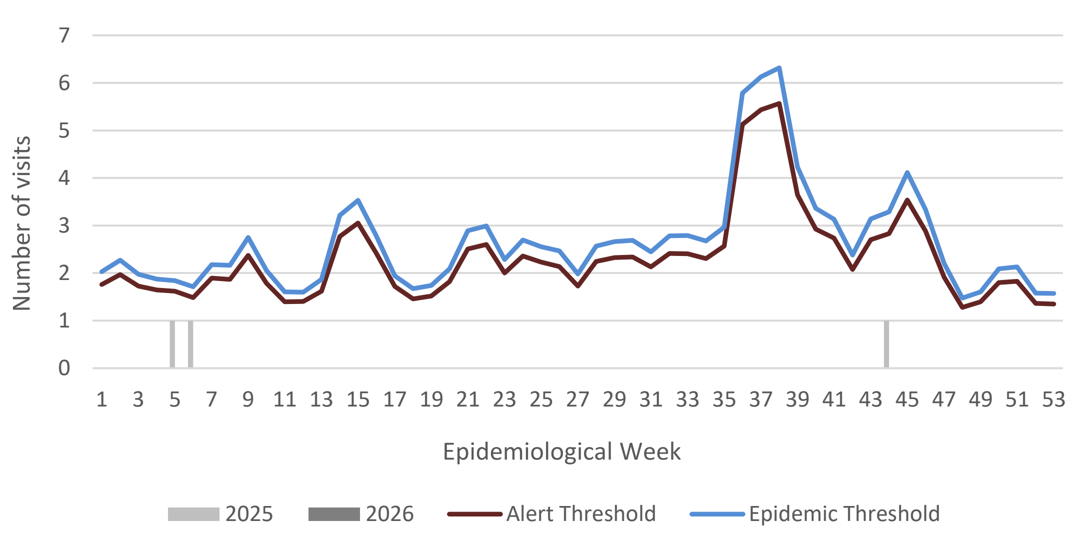
Temperature of >38⁰*C* /100.4⁰*F* (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice.



FEVER AND JAUNDICE

Temperature of >38⁰*C* /100.4⁰*F* (or recent history of fever) in a previously healthy person presenting with jaundice.

The epidemic threshold is used to confirm the emergence of an epidemic in order to implement control measures. It is calculated using the mean reported cases per week plus 2 standard deviations.



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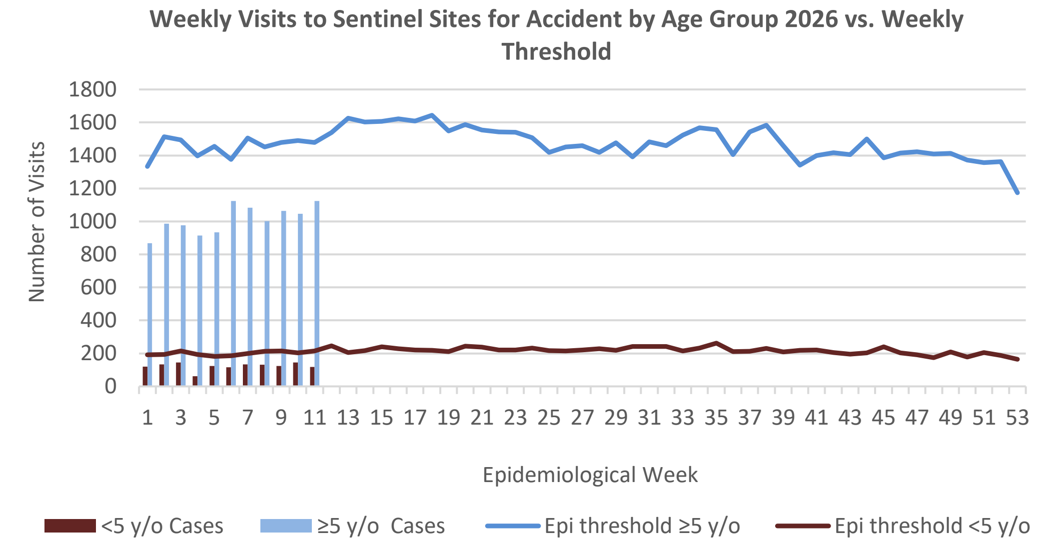
ACCIDENTS

Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.



VIOLENCE

Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.

Weekly Visits to Sentinel Sites for Violence by Age Groups 2026 vs. Weekly Threshold

Number of Visits

600
500
400
300
200
100
0

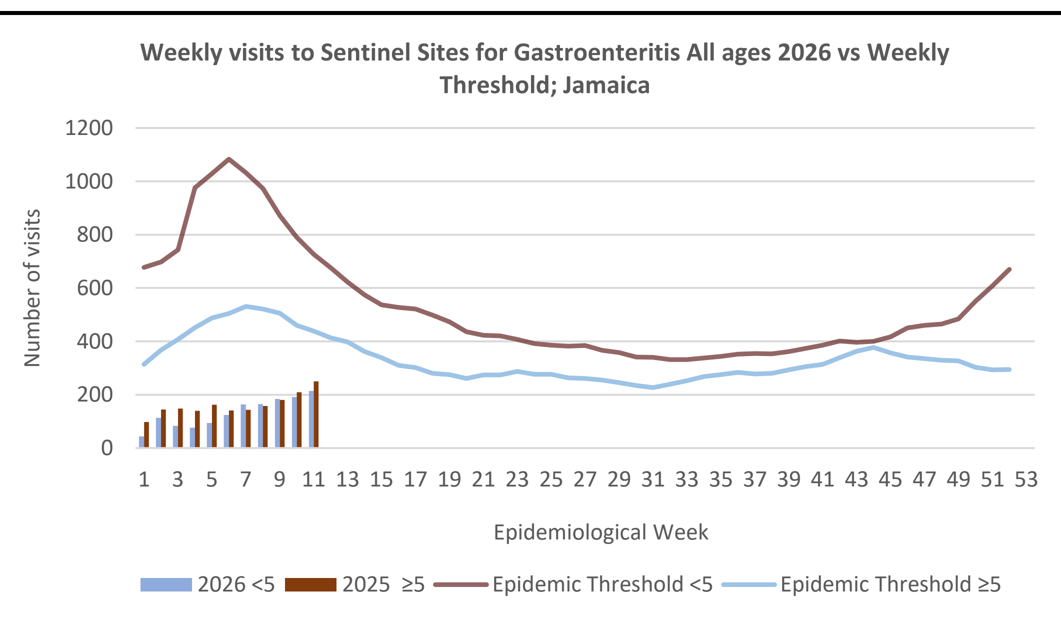
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53

Epidemiological Week

<5 y.o
≥5 y.o
Epi Threshold <5 y/o
Epi Threshold ≥5y/o

GASTROENTERITIS

Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.



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CLASS ONE NOTIFIABLE EVENTS

	CLASS 1 EVENTS		Confirmed YTD$^{\alpha}$ CURRENT YEAR 2026	Confirmed YTD$^{\alpha}$ PREVIOUS YEAR 2025
NATIONAL /INTERNATIONAL INTEREST	Accidental Poisoning		4$^{\beta}$	46$^{\beta}$
	Cholera		0	0
	Severe Dengue$^{\gamma}$		See Dengue page below	See Dengue page below
	COVID-19 (SARS-CoV-2)		3	40
	Hansen's Disease (Leprosy)		0	0
	Hepatitis B		2	2
	Hepatitis C		0	1
	HIV/AIDS		NA	NA
	Malaria (Imported)		0	0
	Meningitis		1	6
	Mpox		0	0
EXOTIC/ UNUSUAL	Plague		0	0
H IGH MORBIDITY/ MORTALITY	Meningococcal Meningitis		0	0
	Neonatal Tetanus		0	0
	Typhoid Fever		0	0
	Meningitis H/Flu		0	0
SPECIAL PROGRAMMES	AFP/Polio		0	0
	Congenital Rubella Syndrome		0	0
	Congenital Syphilis		0	0
	Fever and Rash	Measles	0	0
		Rubella	0	0
	Maternal Deaths (notified pregnanacy related deaths)$^{\delta}$		8	15
	Ophthalmia Neonatorum		0	20
	Pertussis-like syndrome		0	0
	Rheumatic Fever		0	0
	Tetanus		0	0
	Tuberculosis		4	12
	Yellow Fever		0	0
	Chikungunya$^{\varepsilon}$		0	0
	Zika Virus$^{\theta}$		0	0

Comments

AFP Field Guides from WHO indicate that for an effective surveillance system, detection rates for AFP should be 1/100,000 population under 15 years old (6 to 7) cases annually.

Pertussis-like syndrome and Tetanus are clinically confirmed classifications.

$^{\gamma}$Dengue Hemorrhagic Fever data include Dengue related deaths;

$^{\delta}$ Figures include all deaths associated with pregnancy reported for the period.

$^{\varepsilon}$ CHIKV IgM positive cases

$^{\theta}$ Zika PCR positive cases

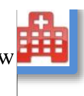
$^{\beta}$ Updates made to prior weeks.

$^{\alpha}$ Figures are cumulative totals for all epidemiological weeks year to date.

NA- Not Available

NOTIFICATIONS- All clinical sites

INVESTIGATION REPORTS- Detailed Follow up for all Class One Events



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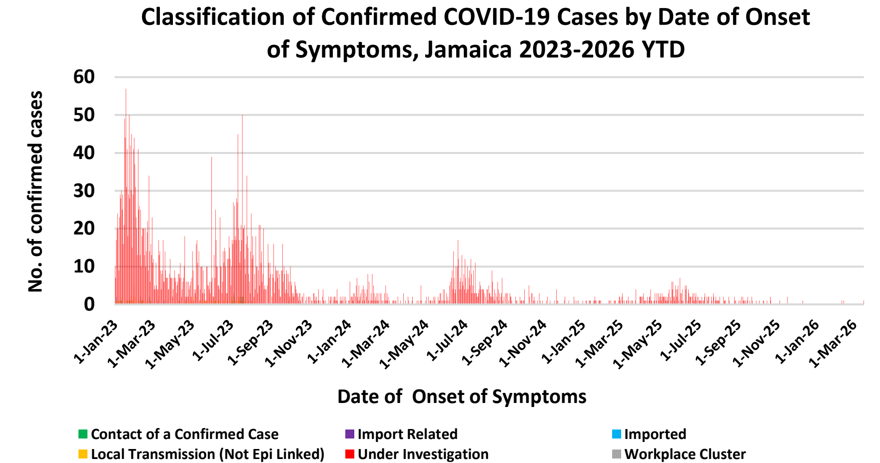
COVID-19 SURVEILLANCE

CASES	EW 11	Total
Confirmed	0	157753
Females	0	90885
Males	0	66865
Age Range	-	1 day to 108 years

* 3 positive cases had no gender specification
* PCR or Antigen tests are used to confirm cases
* Total represents all cases confirmed from 10 Mar 2020 to the current Epi-Week.

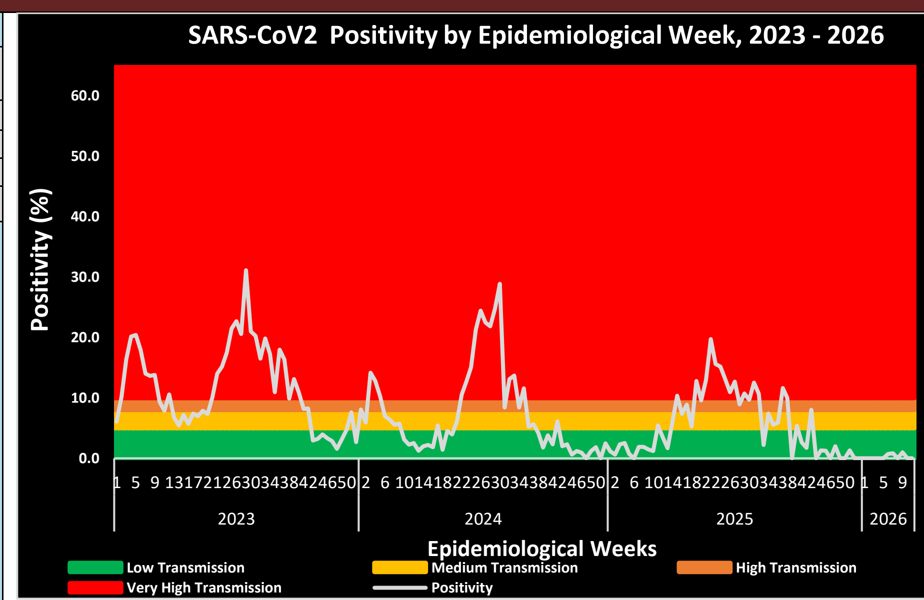


COVID-19 Outcomes

Number of Confirmed COVID-19 cases and deaths, Jamaica 2022-2026

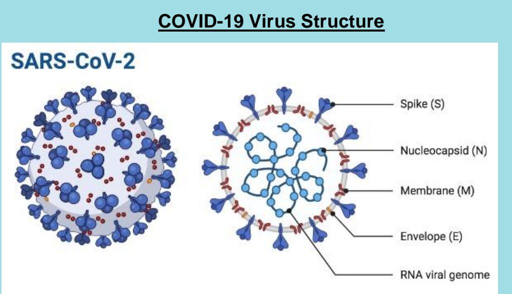
COVID-19	Year					
	2022	2023	2024	2025	2026	Total (2020-2026)
Cases	55,721	3,842	705	315	3	157,753
Deaths	621	116	24	13	0	3,921

*Current positivity rate: 1.0%
- (positive samples/total samples tested)
* Low transmission for infection



COVID-19 Parish Distribution and Global Statistics

COVID-19 Virus Structure



COVID19 Cases by Parish

Total Cases: Hanover 4675; Trelawny 18055; St. James 5241; St. Ann 11569; St. Mary 4981; Westmoreland 9030; St. Elizabeth 6658; Manchester 9047; Clarendon 7895; St. Catherine 28412; Kingston & St. Andrew 42101; Portland 4036; St. Thomas 6053

Legend: Confirmed COVID19 Cases by Parish: 4036 - 6053; 6054 - 9047; 9048 - 18055; 18056 - 28412; 28413 - 42101; Parishes

EW 11 Cases: 0 in all parishes

Legend: COVID19 Cases by Parish March 15 - March 21, 2026: 0; Parishes

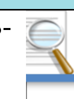
Date Prepared: April 1, 2026

MINISTRY OF HEALTH & WELLNESS

COVID-19 WHO Global Statistics EW 8 -11 2026

Epi Week	Confirmed Cases	Deaths
8	12300	354
9	10400	279
10	7000	151
11	5500	205
Total (4weeks)	35200	989

NOTIFICATIONS- All clinical sites



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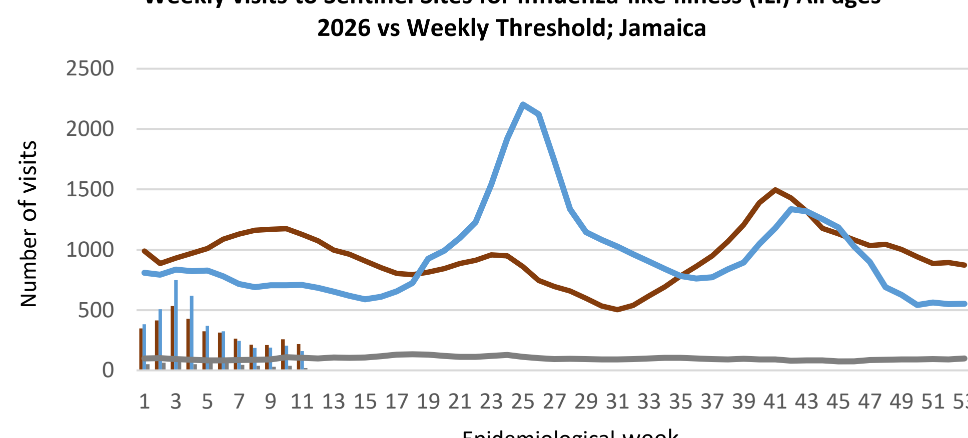
INFLUENZA SURVEILLANCE

EW 11

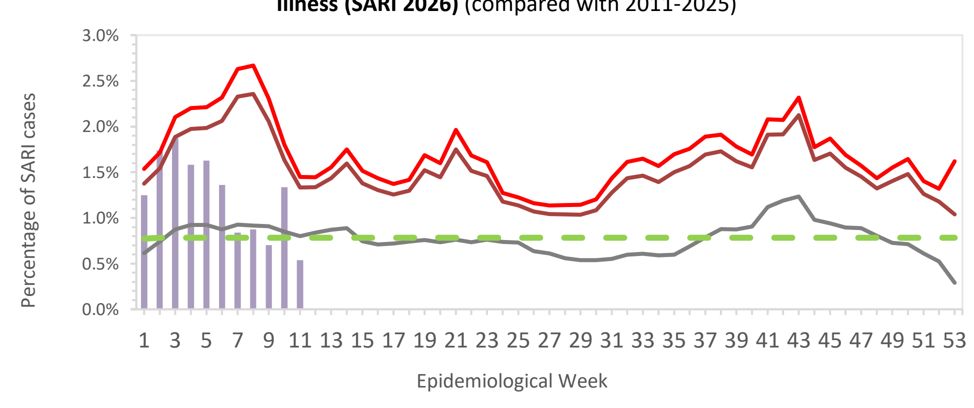
March 15, 2026 – March 21, 2026 Epidemiological Week 11

	EW 11	YTD
SARI cases	7	212
Total Influenza positive Samples	**0**	**236**
Influenza A	**0**	**193**
H1N1pdm09	0	14
H3N2	0	179
Not subtyped	0	0
Influenza B	**0**	**9**
B lineage not determined	0	0
B Victoria	0	0
Parainfluenza	0	0
Adenovirus	0	0
RSV	0	34



Epi Week Summary

During EW 11, seven (7) SARI admissions were reported.

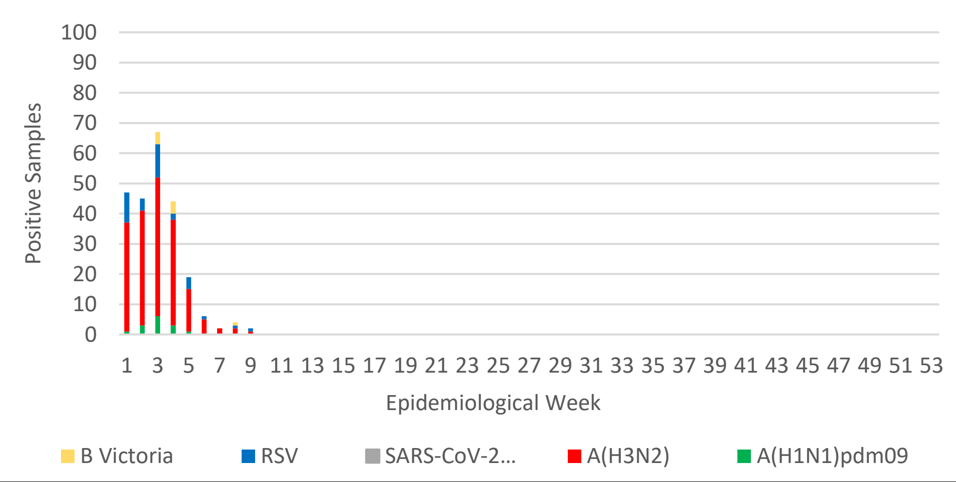


Caribbean Update EW 11

(Updates as at EW 9)

Influenza circulation remained elevated, with a slight increase compared to the previous EW (19.9%), following a sustained decrease in February. Influenza A(H3N20 premoninated over the past four weeks. Both RSV and SARS-CoV-2 showed slight increases, reaching 3.4% and 1.1% positivity, respectively.

(Retrieved from PAHO Respiratory viruses weekly report) https://www.paho.org/en/influenza-situation-report



NOTIFICATIONS- All clinical sites

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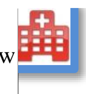
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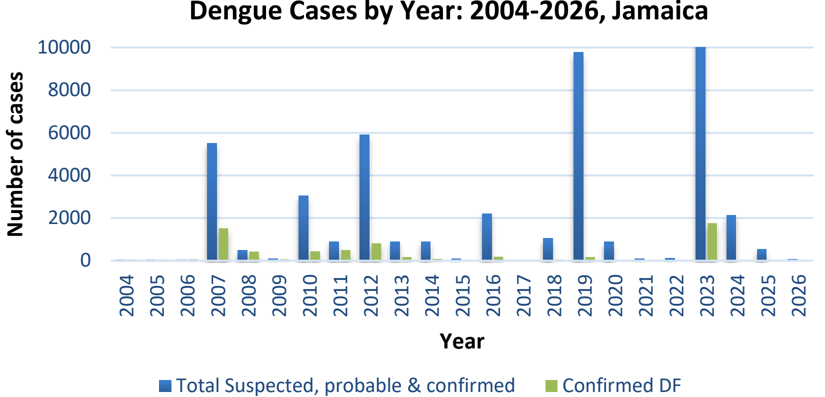
DENGUE SURVEILLANCE

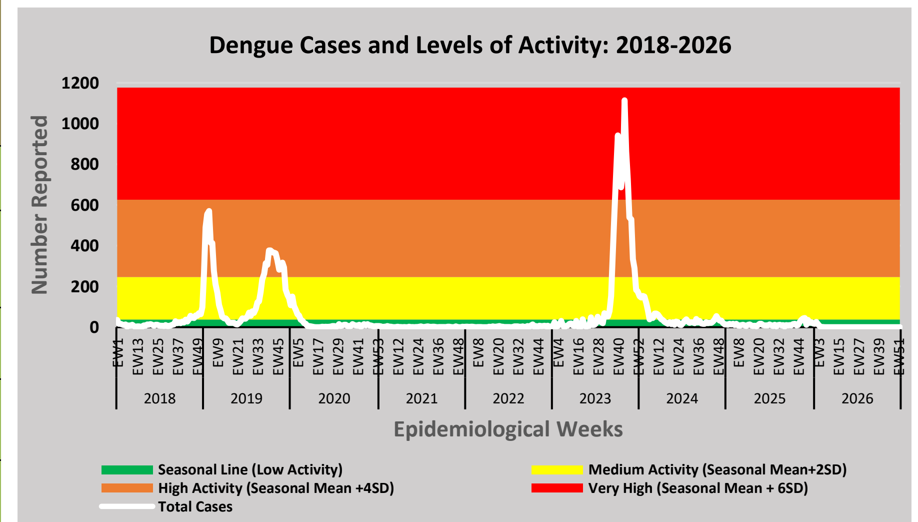
March 15, 2026 – March 21, 2026 Epidemiological Week 11

Epidemiological Week 11



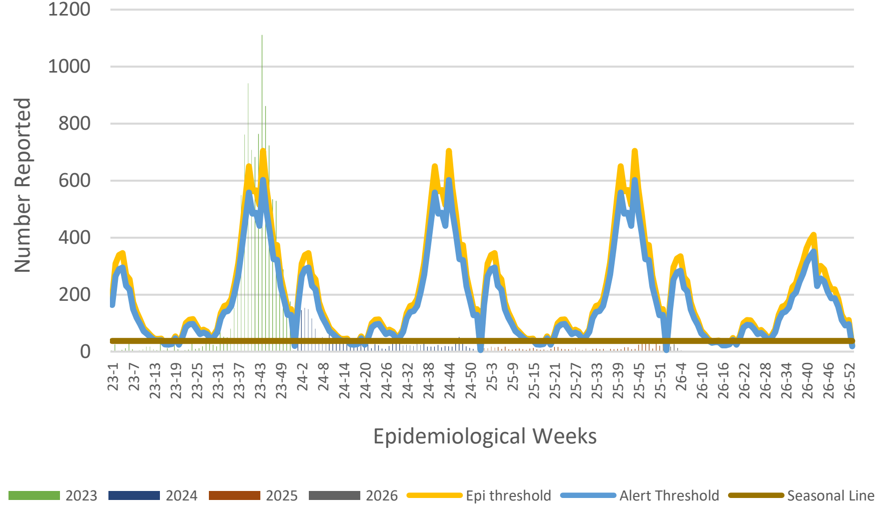
Reported suspected, probable and confirmed dengue with symptom onset in week 11 of 2026

	2026*	
	EW 11	YTD
Total Suspected, Probable & Confirmed Dengue Cases	0	64
Lab Confirmed Dengue cases	0	1
CONFIRMED Dengue Related Deaths	0	0



Points to note:

- **Dengue deaths are reported based on date of death.**
- ***Figure as at March 27, 2026**
- **Only PCR positive dengue cases are reported as confirmed.**
- **IgM positive cases are classified as probable dengue.**



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RESEARCH ABSTRACT

Abstract

NHRC-24-O-18

Social Support and Risk for Cognitive Impairment among Community-Dwelling Older Persons in Jamaica

Donaldson-Davis, K[1], Willie-Tyndale, D[1], Edwards, T[1], McKoy-Davis J[1], Chin-Bailey C[2] , James, K[2], Eldemire-Shearer, D[1]

[1]Mona Ageing and Wellness Centre, University of the West Indies, Mona, Jamaica, [2]Department of Community Health and Psychiatry, University of the West Indies, Mona, Jamaica

Objective: To describe social support among older Jamaicans by Mini-Mental Status Examination (MMSE) scores.

Methods: A nationally representative survey was conducted in 2012 among persons ≥ 60 years (n = 2,943). MMSE scores were available for 2,782 participants. Number of children alive, quality of relationship with children, source of main physical and emotional support, caregiver presence and number of visiting contacts were used as indicators of social support. MMSE scores <20 were categorized as low. Logistic regression, incorporating demographic and support variables, was used to identify factors associated with low MMSE scores.

Results: One-tenth of persons with low MMSE scores had no children and 8.9% of persons with low scores rated relationships with their children as poor or non-existent. The plurality of persons considered themselves their main physical and emotional support. Seventy-three percent of persons with low scores had no caregiver. Older age, female gender and ≤ primary education level were associated with low MMSE scores. High quality relationships with children were less likely among the lower MMSE score category [OR 0.69, 95% CI: 0.517 – 0.919]. Persons with caregivers were more likely to be in the lower score category [OR 2.2, 95% CI: 1.6 – 3.1].

Conclusion: Low MMSE scores are associated with increased risk of cognitive impairment. Many community-dwelling older persons at risk for cognitive impairment lack adequate social support. Persons with low MMSE scores should receive close clinical surveillance, and be prioritized for community based social support interventions. Programmes incentivizing caregiving could benefit cognitively impaired older persons.

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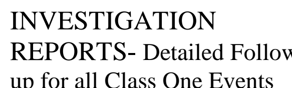

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